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Transparency about Painkillers: A Remedy for the Evaluativist's Headache

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Abstract

The paradox of pain is that pain is in some ways like a bodily state (when you have a pain in your shin, what you care about is the state of your shin, not the state of your mind) and in other ways like a mental state (if it feels like you are in pain, then you are in pain). How can a state both be in your shin and in your mind? Evaluativism is a promising answer. According to evaluativism, unpleasant pain experience represents bodily disturbance as normatively bad. Evaluativism goes some way toward addressing the paradox of pain, by allowing that pain is a kind of experiential state, while also explaining how that state brings you to care about a bodily condition — namely, by telling you that it is bad that that condition obtains. But the paradox still confronts evaluativism in the form of the *killing the messenger* objection: while the evaluativist has a nice story about the rationality of tending to the wound and other body-directed responses to pain, this story on its own cannot explain the rationality of responses to pain, like taking painkillers, that seem to be experience-directed. Evaluativists have offered accounts of experience-directed responses to pain, but I will argue that these accounts conflict with the Transparency thesis — the claim that we cannot access our experiences non-inferentially. Evaluativism and Transparency are natural bedfellows, so this is a problem for evaluativists. Having argued as much, I will go on to develop a new evaluativist account of taking painkillers which does not conflict with Transparency. I call it *naïve evaluativism*. According to naïve evaluativism, we experience painkillers as making tissue damage or disruption less bad, and absent further reflection, that is why we take them.

1 Introduction

Evaluativism is the view that pain experience represents some bodily state or event as both a disturbance, and as bad (in the normative sense of something that ought not happen, rather than the descriptive sense of 'extreme').[1] For example, the experience of pain in your shin tells you that a disturbance that ought not happen is happening in your shin.[2]

Some of our actions in response to pain experience, like tending to a wounded shin, are body-directed, in the sense that they aim at the modification of a bodily state. On some views, these aims are instrumental: you try to heal the wound in your shin in order to cause your pain experience itself to diminish or cease. But the evaluativist has an attractive alternative account, according to which your ultimate aim in tending to your shin is to make your wound less *bad*. Moreover, the evaluativist can say that your pain experience itself *rationalizes* this action, in much the same way that your doctor's telling you that something is wrong with your shin rationalizes your tending to your shin: by telling you something that counts in favor of your doing so.[3] Some evaluativists have argued that evaluativism should be preferred on this basis because no other view offers as plausible of an

[1] Strictly, the evaluativist claim should be restricted to *unpleasant* pain experiences (see Bain 2013). But nothing we say below will hinge on the subtleties of such cases, so for ease of exposition in the main text I omit the requirement that the pains in question be unpleasant.

[2] See for example Bain (2011), (2013), (2014), Boswell (2016), Cutter and Tye (2011), (2014), Helm (2002), O'Sullivan and Schroer (2012).

[3] This is not to say that the rationalization requires that you form a *belief* on the basis of your pain experience. For discussion of the view that unpleasant pain experiences rationalize action see Bain (2013), Martinez (2015), Boswell (2016). Note that I do not claim here (as Bain 2013 and others do) that unpleasant pain experiences are essentially motivating. On some accounts, pain asymbolics may experience pain that is not unpleasant, but on other accounts pain asymbolics experience unpleasant pain but fail to be motivated by it (see Bain 2011, Corns 2014a, Klein 2015 for discussion). On this view, asymbolia is akin to one failing to form beliefs on the basis of one's perceptual experience.

account of the rationality of our body-directed responses to pain experience.[4]

But some of the actions that we perform in response to pain experience seem to be experience-directed. For example, many suppose that typically, the aim of taking a painkiller is getting rid of the pain — i.e., causing the experience of pain to diminish or cease. I will be challenging this claim below, so I will resist calling actions such as taking painkillers 'experience-directed.' I will instead call them 'painkilling actions', where I stress that I mean for this to be neutral on whether they are genuinely experience-directed.

Not all evaluativists share my reservations. Many evaluativists (including Bain 2013, Boswell 2016, Cutter and Tye 2014 and O'Sullivan and Schroer 2012) accept roughly the following claim:

(OPAQUE AIMS): The aim of all normal painkilling action is the cessation or diminution of the pain experience.

OPAQUE AIMS may sound a little strong, but it just says that if a painkilling action doesn't aim at the cessation or diminution of pain experience then there is something abnormal about it. If a nefarious villain tells you to take a painkiller or else, your motives needn't pertain to your pain experience, but this case is clearly abnormal. Similarly you might just have an unintelligible compulsion to take painkillers (*à la* Quinn 1993's radioman), but in the relevant sense that is not normal either.[5]

[4]See e.g. Helm (2002), O'Sullivan and Schroer (2012) and Bain (2013).

[5]Most evaluativists would accept the more specific claim that the aim of all *rational* painkilling action is the cessation or diminution of the pain experience, barring extraneous or deviant motivations like the nefarious villain mentioned above. On Cutter and Tye (2014)'s view, however, desires in general, including ones that motivate painkilling action, are arational. Still, they argue that the normal motivation to take painkillers is a desire to make one's pain experience cease. A brute compulsion to swallow aspirin pills might be no less rational, for them, but it would still be abnormal.

How can evaluativists embrace OPAQUE AIMS? If what a pain in your shin tells you is that there is something wrong with your shin, and that is all it tells you, then there is nothing it tells you that counts in favor of actions that aim to modify your experience itself, any more than in telling you that there is something wrong with your shin, the doctor tells you something that counts in favor of your asking her to leave the room. But then how could it be rational to want to modify your experience itself?

This is the core of the *killing the messenger* objection, the objection that according to evaluativism, taking painkillers is no more rational than killing the messenger (or rudely asking her to leave).[6] But so formulated it is not decisive, because evaluativism does not automatically commit one to the claim that *all* action in response to pain is rationalized by pain experience in quite the way that paradigmatic body-directed responses to pain experience are.

Many evaluativists have responded accordingly: by endorsing OPAQUE AIMS (i.e., saying that normal painkilling actions are experience-directed) and arguing that experience-directed responses to pain have a rational structure distinct from that of body-directed responses to pain. These evaluativists have acknowledged and adequately addressed some challenges to this approach.[7] But other challenges remain. In §2 I present two further challenges for evaluativists who endorse OPAQUE AIMS.

[6]The objection has been deployed (e.g. in Jacobson 2013) against all views on which pain experience rationalizes body-directed responses to pain but not painkilling actions. So construed it also targets imperativists, who hold that pain experience has imperative body-directed content rather than indicative body-directed content, but I restrict my attention to evaluativists here. The killing the messenger objection is presented in Hall (1989), Jacobson (2013), Aydede and Fulkerson (2015), Brady (2015) and considered in Bain (2013), Boswell (2016), Cutter and Tye (2014), Klein (2015), Martinez (2015) and O'Sullivan and Schroer (2012), among other places.

[7]See again Bain (2013), Boswell (2016), Cutter and Tye (2014) and O'Sullivan and Schroer (2012).

This might sound like ammunition for opponents of evaluativism, because OPAQUE AIMS might seem to be undeniable. But in §3 I will present naïve evaluativism, a version of evaluativism which denies OPAQUE AIMS. Naïve evaluativism says that some normal painkilling actions aim at diminishing the bodily badness that pain experience represents, just as body-directed actions like tending to the wound do. This will be enough to address the challenges I present in §2. In §§4-6 I consider and respond to important objections to the naïve evaluativist account.

2 Troubles with Opaque Aims

Say that to *become non-inferentially aware* of an experience is to become aware of that experience without relying on a conceptually-mediated, inferential process of introspection. A motivation for evaluativism is its connection to the following principle:

(TRANSPARENCY): One cannot become non-inferentially aware of one's own experiences (as opposed to the things they represent).

Assuming that we can be non-inferentially aware of anything that can make a difference to our phenomenology, TRANSPARENCY supports the *strong representationalist* thesis that the phenomenology of experiences is fully determined by what they represent (i.e., their content). Strong representationalism in turn is a motivation for evaluativism: pain and other affective states have traditionally presented challenges for strong representationalists, and evaluativism offers an attractive response to these challenges.[8]

[8]See in particular Cutter and Tye (2011), (2014), and Boswell (2016).

If OPAQUE AIMS and TRANSPARENCY are both true, then in normal painkilling action, we aim at the modification of a state that we rely on inference to become aware of. Consider the socially anxious person who inferentially introspects his social anxiety and determines to have a few drinks to loosen up. Given OPAQUE AIMS and TRANSPARENCY, the rational structure of normal painkilling action must be akin to the rational structure of the socially anxious person's decision to have a drink.[9]

Clearly painkilling action *can* have this structure. But here the contention is not only that painkilling actions occasionally have this structure; it is that all normal painkilling actions have it. This is what follows from the conjunction of TRANSPARENCY and OPAQUE AIMS. I will now (in the remainder of §2) present two difficulties for this strong claim. I will suggest that in light of these difficulties, evaluativists should reject OPAQUE AIMS. I then address the question of how to do so in §§3-6.

2.1 Aim Awareness

When pain experience is sufficiently intense, its immediacy is undeniable: we seem to be unable to focus on or attend to anything else. It is particularly plausible that we are non-inferentially aware of our pain experience when that experience is so intense that we cannot focus on anything else.

The friend of TRANSPARENCY must resist such a characterization. But at very least, what seems clear — in the sort of case where you are laid up in a hospital bed blinded by your pain and can think of nothing else but how to get more morphine

[9]Cf. Boswell (2016) as well as Cutter and Tye (2014). Bain (2013) and O'Sullivan and Schroer (2012) both adduce introspectible features of pain experience.

— is that in these cases you are non-inferentially aware of the states that your painkilling actions aim to modify. And there is nothing abnormal about this kind of painkilling action. In other words:

(AIM AWARENESS): We can be non-inferentially aware of the states that some normal painkilling actions aim to modify.

Of course we are not always non-inferentially aware of the states or objects that we aim to impact with our actions. If you are far away and I am trying to call you on the telephone, I am not non-inferentially aware of you. But if I am trying to catch the ball coming toward me then (hopefully) I am non-inferentially aware of the ball. AIM AWARENESS is the claim that in the sort of case where you are tempted to grab the doctor by the collar and not let her go until she gives you more morphine, you are as non-inferentially aware of the states you hope to modify as ever you might be.

The claim here is not that inference is necessarily slow, while response in very urgent cases is fast (though try counting backwards from one hundred by sevens when you are in blinding pain). The point is that if we have any grip at all on what non-inferential awareness is (that doesn't just analyse it as whatever makes a phenomenal difference), then the states that we aim to modify when in blinding pain are paradigm cases.

Evaluativists can accommodate both AIM AWARENESS and TRANSPARENCY, but only if they reject OPAQUE AIMS. AIM AWARENESS together with OPAQUE AIMS entails that you can be non-inferentially aware of your pain experience itself, contradicting TRANSPARENCY.

2.2 Semantic Priority

In ordinary usage, the claim 'my back hurts' seems to be immune to correction. Even if a doctor runs tests and informs me that there is no disruption or damage in my back, I am well within my rights to maintain that my back hurts. It is tempting to declare that there can be no such thing as a hallucinatory experience of pain, and accordingly that we have no 'objective' or 'perceptual' concept corresponding to the terms 'hurts' or indeed 'pain': the only concepts we express with these terms are subjective concepts.

Aydede (2014) and others have deployed this thought to challenge TRANSPARENCY. TRANSPARENCY suggests that we can only have the subjective concept of a certain experience type if we have the objective concepts of the things that experience represents. But then TRANSPARENCY is false if we lack objective concepts corresponding to pain experience while possessing subjective ones.[10]

This challenge, though important, is only as strong as the claim that we lack objective concepts corresponding to pain experience. Evaluativists and others have challenged that claim.[11] But there is a related challenge, the *semantic priority* challenge, which concedes that we possess objective concepts corresponding to pain experience. This challenge alleges only that the correction-immune concepts we deploy at the doctor's office are more *central* to our ordinary usage than any objective concepts that yield judgments vulnerable to the doctor's correction. On this challenge the core claim is that the concept **hurts** picks out the state we want to do something about even if the doctor tells us nothing is wrong. In other words:

[10]For this worry see Aydede (2014) and Aydede and Fulkerson (2014), Block (1996),(2006), and Hill (2006) and for replies see Tye (2006), Byrne (2008) and Martinez (2011).

[11]E.g.., Tye (2006) and Byrne (2008).

(PURPOSIVE DISCOURSE): The concept **hurts** as it is deployed at the doctor's office picks out features of the states that (some) normal painkilling actions aim to modify.

Note that if OPAQUE AIMS is false, then the evaluativist who embraces PURPOSIVE DISCOURSE can say that the feature in question — the feature picked out by the concept **hurts** as it is deployed at the doctor's office — is the bodily badness of the state of disruption or tissue damage. On this view (which I elaborate in §§3-6 below), the correction-immunity of first personal deployments of the term arises because while the doctor (or in some cases, our eyes) can correct what the pain tells us about tissue damage, the doctor (or our eyes) cannot correct what the pain tells us about the *badness* of our bodily states.

On the other hand if OPAQUE AIMS is true, PURPOSIVE DISCOURSE implies that the concept **hurts** that we deploy at the doctor's office is a subjective or experiential concept, one that picks out the unpleasantness of the experience, or perhaps the badness of that unpleasantness. But TRANSPARENCY predicts that our objective concepts should be more salient and central in our usage generally, and the doctor's office is a paradigmatic context for the deployment of pain concepts, so it is a challenge to TRANSPARENCY if the salient concept in this context is the subjective rather than the objective one.[12]

There is also a further source of tension between OPAQUE AIMS and PURPOSIVE DISCOURSE which does not appeal to TRANSPARENCY. Reuter (2017) cites developmental evidence that children linguistically report on pain by 18-24 months,[13] but do not yet linguistically report on their introspective states as such until after age

[12]See Aydede (2014), Boswell (2016), Martinez (2011), Tye (2002) and Dretske (1995).
[13]Franck et al. (2010), Stanford et al. (2005).

three.[14] Even if children possess introspective concepts by 18 months (on which more below) the linguistic data is still evidence that the objective has priority over the subjective in the developmental process, which makes for tension with PURPOSIVE DISCOURSE if OPAQUE AIMS is true. The two year old who tells the doctor that it hurts presumably reports on the same thing that an adult would.

3 Naïveté Regained

When we take painkillers, our pain experience diminishes or ceases. The core claim of the evaluativist theory is that pain experience presents a state of tissue damage or related disturbance as *bad*.[15] It follows that on the evaluativist view, our experience on taking (effective) painkillers is experience as of our tissue damage becoming less bad.[16]

Suppose you are in a room and there is a button. The button is connected to your brain, and it acts on your conscious states: it causes you to see the room as getting darker. Absent any further information, you will probably conclude that the button makes the room darker.

The starting point of the naïve evaluativist position is the observation that, if evaluativism is true, then the evidence of your pain experience on taking painkillers is analogous to the evidence of your visual experience on pushing the button. Given evaluativism, what you experience when you take painkillers is that the

[14] Flavell et al. (1990); Fabricius and Weimer (2010).

[15] See again Bain (2013), Boswell (2016), Cutter and Tye (2014), Helm (2002), O'Sullivan and Schroer (2012).

[16] I am assuming for ease of presentation that in this case, a change of experience constitutes or causes an experience of change. We can drop this assumption since strictly, all that matters is that one can learn from the relevant sequence of experiences that the wound is not as bad after one took painkillers.

tissue damage or disruption becomes less bad.

The naïve evaluativist makes two further claims. First, our taking painkillers is rational if it is based on what we have learned in this way (i.e., that painkillers make the tissue damage or disruption less bad), absent any introspection or thought about our experiences themselves. Second, this rationale for taking painkillers underwrites some normal instances of painkilling action (falsifying OPAQUE AIMS). A more ambitious position, call it *strong naïve evaluativism*, adds that this justification for taking painkillers can survive sustained scrutiny, because for all we know painkillers actually do make the tissue damage or disruption less bad. Naïve evaluativism does not hinge on strong naïve evaluativism, but I will defend both below; first naïve evaluativism (here below and in §§4-5) and then strong naïve evaluativism (in §6).

An initial objection to naïve evaluativism is that, while the experience of taking painkillers may be experience of tissue damage or disruption becoming less bad, one has but to take a second look to notice that one's wounds have not actually healed because of the painkillers one has taken. So overall, one does not learn from experience that painkillers make damage or disruption less bad.

Two points in reply. First, some painkillers — anti-inflammatories like aspirin — actually do reduce tissue damage, by reducing inflammation. And in many cases it is hard to tell what helps to mend a wound and what does not. Consider rubbing a scraped shin. As it happens, rubbing a shin does not help heal the scrape. Instead, it is a painkilling mechanism: rubbing the shin quiets the nerves (that is, it creates a competing stimulation that antagonizes peripheral nociceptors).[17] Or

[17]For a primer on gate control theory see Melzack and Wall (1996). See Klein (2015) for discussion.

consider massaging a bruised muscle with a foam roller. Does doing so loosen a spasm, or serve as a gate-control mechanism like rubbing a scrape?[18]

Second, in the germane (normative) sense, one can experience a change in how bad a wound is, without experiencing the wound as healing. Even if the badness is predicated of the wound, it still may be sensitive to changes beyond the wound. For example, the badness might be a measure of how bad a wound is for-the-subject. Then something makes the wound less bad without healing it by diminishing its consequences for the subject. By analogy, it may be bad for you that the bridge is down, and you can make it less bad by fixing the bridge, but also by finding another way to get where you are going. The moral is that observing that your wound is not healing does not undermine your experience of the wound becoming less bad upon taking painkillers, provided that that experience is not experience of the wound becoming less bad in virtue of healing.

According to naïve evaluativism, OPAQUE AIMS is false. AIM AWARENESS is true because we are non-inferentially aware of the badness of bodily states that pain experience represents. PURPOSIVE DISCOURSE is true because the concept **hurts** that we deploy at the doctor's office points to the badness of bodily states that pain experience represents. Thus naïve evaluativism resolves the challenges to evaluativism developed in the previous section while allowing the evaluativist to retain TRANSPARENCY.

The naïve evaluativist recognizes continuities that friends of OPAQUE AIMS must deny. Consider again the action of rubbing a scraped shin. As noted, rubbing a shin is a painkilling mechanism which does not help heal the scrape. For the OPAQUE AIMS theorist, shin-rubbing is hard to classify: it is a painkilling action in its effects,

[18]Thanks to an anonymous referee for the latter example.

but its rational structure is that of a body-directed action. Is there something abnormal about it? For the naïve evaluativist, shin-rubbing is a paradigmatic case of painkilling action.

Consider also the self-comforting behavior of infants and toddlers. Pacifier-sucking is a reflex in infants, but there is evidence that it can occur as a voluntary response to distress by ten months.[19] And while ten-month olds may possess some components of introspective concepts,[20] they generally do not pass the rouge test, a standard mirror recognition challenge, until around 24 months.[21]

In response to this concern (though he does not specify a developmental age at which the issue is most salient), Boswell (2016) suggests that infants lack the 'usual' rationale for painkilling action, and that they "really think" that pacifiers "alleviate the hurt or injury." (*id.* p. 2985). On Boswell's theory OPAQUE AIMS is true for adults, but not for ten-month olds. This leaves us with a puzzle: How, when and why does the norm for painkilling action go from being world-directed to being experience-directed?[22] In contrast, the naïve evaluativist does not have

[19]Braingart-Rieker and Stifter (1996 p. 1775) find that by 10 months pain- and emotion-regulatory behaviors are voluntary in some context and decouple from basic pain reactivity. Rothbart, Posner, and Boylan (1990) find that infants voluntarily control attention to regulate distress (though not necessarily pain) as early as three months.

[20]Meltzoff and Brooks (2008) find that twelve-month olds who have been trained by wearing a blindfold do not gaze-follow blindfolded adults, while twelve-month olds without training do, which is evidence that twelve-month olds possess concepts of experience in some form.

[21]Amsterdam (1972).

[22]Boswell's answer is that the act of introspecting one's pain experience automatically re-purposes certain emotional states into states that rationalize painkilling action (*id.* p. 2984). But this makes it too easy: intuitively it can be incidental to the aims of my painkilling action whether I happen to be introspecting the fact that I am in pain. Consider a toddler who has the capacity to introspect but who firmly believes that pacifiers heal wounds. Plausibly, the aims of such a toddler in reaching for a pacifier when experiencing pain might remain the same as always even if that toddler happens to introspect on the pain experience (suppose the toddler is playing the introspection game, indiscriminately enumerating the mental states he is in). Reuter (2017) defends an approach closer to naïve evaluativism. According to Reuter, the evidence concerning children's pain reports establishes that they deploy perceptual rather than introspective concepts of pain, and so for the most part do adults. For Reuter, the explanandum is why we

to explain the shift in what normal painkilling action entails, because the naïve evaluativist denies that body-directed painkilling action ever ceases to be normal.

4 Correction Immunity

In this section, I will look more carefully at the naïve evaluativist explanation of the fact that if you experience pain, you are reasonable to seek out painkillers, even if the doctor tells you that there is nothing wrong with the pained part of your body. How can the naïve evaluativist explain this fact, if the naïve evaluativist says that we take painkillers in order to make tissue damage or disruption less bad? If the doctor tells you that there is nothing wrong with the relevant part of your body, how can you reasonably go on taking action to make something that is wrong in your body less bad?

In response there are two points to make. First, perceptual experiences are notoriously recalcitrant: they can persist even if we know them to be illusory, and as long as they persist, the temptation to believe and act accordingly can be quite strong. It takes a great deal of focus to bear in mind that the lines presented in a Müller-Lyer illusion are the same length, even if you drew them yourself. And in the case we are concerned with, belief is not the issue — rather, action is. Even

mistakenly think that adults deploy an introspective concept of pain rather than a perceptual one. The explanans is that we are misled by evidence of the incorrigibility, certainty and subjectivity of our pain reports, by various idiosyncratic turns of phrase (i.e., language games), and by general development of knowledge about the mental states of others (pp. 278-281). While I concur with Reuter that factors in the vicinity of these contribute to the misdiagnosis that the mature conception of pain is introspective, I worry that Reuter's account does not go far enough. In particular, he does not address the killing the messenger objection, and so he does not say whether he takes introspective (rather than perceptual) conceptions of pain to be in play where painkilling-action is concerned. If so, he presumably accepts OPAQUE AIMS, and his account is subject to the worries I have raised above. If not, then he owes us a further story about how perceptual concepts of worldly states can rationalize painkilling action.

if you are quite sure that the projectile hurtling toward you is illusory, you're still going to incline to duck. This standard recalcitrance, applied to our case, is enough to at least explain why someone might persist in seeking painkillers after having been told that there is nothing wrong.[23]

But more can be said. At most, the doctor can tell you about the descriptive state of your body, not its normative state (unless your doctor is a doctor of philosophy!). So the situation you are in when the doctor tells you that your pained body part is fine is, at worst, one of knowing that your experience is *partially* illusory. That is, nothing the doctor says directly undermines the normative content of your pain experience, even if it directly undermines the descriptive content. Your experience might still be partly right, even if it is partly wrong. Arguably, in such cases, you remain within your rational rights to take at face value the undefeated aspects of your experience, even if you ought to reject the defeated aspects.

Consider, for example, the case where you see a blue square, only to learn that your color perception had been tampered with. In this case, you may rationally continue to believe that you are in the presence of a square, though you should suspend your belief that it is blue. Closer to home, consider cases of referred pain, in which a disorder in one part of your body can lead to your perceiving pain in another. For example, heart attacks can lead to pain in the neck or back.[24] In cases of referred pain, your experience misrepresents *where* something is wrong, but not *that* something is wrong. And it is plausible that in such a case you remain within your rational rights to believe as much, or to act accordingly.

There is a further question of what might happen were you to learn that your

[23]Thanks to an anonymous referee for stressing this point.
[24]Arendt-Nielsen and Svensson (2001).

body were completely without blemish. Even then, if you continue to feel pain, wouldn't you still be reasonable in seeking painkillers? But cases like this are hard to come by: if you suffer from phantom limb pain, you are missing body parts, which is arguably bad, and you've probably got some nerve damage, which is also arguably bad. Even if you just suffer from a disorder to your central nervous system, that disorder itself is arguably bad. Of course the doctor might tell you that absolutely nothing is wrong with you, even though something is wrong with you. But there remains a question of how irrational it is to disregard the doctor in a case like that, when your experience tells you otherwise. Finally, the naïve evaluativist who holds that one should always heed the doctor may still appeal to the recalcitrance of experience to explain why it is at least understandable, if not rational, that one persists in seeking painkillers in cases like this.

I turn my attention now to another worry confronting the naïve evaluativist. Naïve evaluativism seems to deliver the wrong result about the choices we should make in certain difficult scenarios, for example, scenarios where we must choose between prolonged pain experience and prolonged bodily disturbance. I will address this concern about hard choices in §5 .

I will then, in §6, develop a defense of *strong* naïve evaluativism. Thus far, I have said nothing in defense of the claim that painkillers actually do diminish the badness of tissue damage (excepting anti-inflammatories). Naïve evaluativism does not depend on this claim. Without it, naïve evaluativism amounts to a form of error theory about our painkilling actions. That is enough to reconcile evaluativism and TRANSPARENCY, but it is worth investigating whether more can be said. In §6 I argue that painkillers do in fact diminish the badness of tissue damage, by making it less bad that that tissue damage obtains.

5 Hard Choices

Some painkillers just take the edge off, but others make you comfortably numb. When you are comfortably numb you aren't as careful as you should be: you may put too much weight on your broken shin. Arguably, taking painkillers of this strength undercuts the evolutionary purpose for which you have pain experience in the first place.

Viewed one way, this looks like evidence for OPAQUE AIMS: your aim in taking morphine seems to be in competition with the aims of your body-directed responses to pain.[25] To make this into a direct challenge for the naïve evaluativist, consider the following scenario. Suppose you are in the hospital with a broken shin. You are in excruciating pain, but the doctor tells you the following (good) news: you'll be fully cured in a day. The only question is how to spend the day. You've got to stay in the hospital bed immobilized and drugged up, so there are no indirect consequences either way. But you must choose between option A and option B. Option A will immediately cause your experience of pain to cease, though your wound will remain unhealed until tomorrow. Option B will immediately heal your wound, but your painful experience will linger, as excruciating as ever, until tomorrow. Most of us would likely choose option A over option B, but naïve evaluativism seems to suggest that B is the rational choice.

In reply, I deny that naïve evaluativism makes any claims about the rational choice in this case. Naïve evaluativism does not deny that you can introspect your pain experience and then aim to get rid of it. And the scenario considered here is one in which the doctor has explicitly distinguished between your pain

[25] See e.g. Klein (2015).

experience and its objects, inviting you to bring the results of introspection into your deliberation.

Furthermore, even an obstinately naïve patient who refuses the doctor's invitation to introspection might choose option A. For the scenario does not say how *bad* each option is. And if you think painkillers diminish bodily badness, then you might suppose option A to be an option in which the wound remains but its badness is diminished. In contrast, if your painful experience lingers on option B, then like someone suffering from phantom limb pain, you might well think that there is something bad within you even though its bodily source is hard to pinpoint.

But what if we add the normative details into our stipulation: i.e., we stipulate that in option A there is as much bodily badness as there would otherwise be, and in option B there is none, or in any event, the patient believes as much? This is now a very hard case, especially so if we take pain experience to be intrinsically bad — a question on which naïve evaluativism is neutral. For then the patient faces a stark choice between experiential badness and bodily badness. But even here, naïve evaluativism makes no prediction, because again, the challenge here only arises after an opportunity for introspection. Naïve evaluativism makes no predictions about the exchange rate between the disvalue of bodily badness and the disvalue of experiential badness (if such there be).

Indeed this hard case highlights a further challenge for evaluativists who embrace OPAQUE AIMS: for them, every trip to the medicine cabinet is a version of this hard choice, a choice between diminishing as much experiential badness as possible (at higher risk of further bodily harm) and minimizing further risk of bodily harm (at cost of feeling more pain). But it is implausible that we confront such a deep conflict of values whenever we visit the medicine cabinet. According to the naïve

evaluativist, in ordinary cases the question of whether to take strong painkillers is a more ordinary question of temporal discounting: of whether to favor minimizing bodily badness *now* (by taking painkillers), or *later* (by staying vigilant).

I will now make the case that pain experience's presentation of bodily badness can indeed be veridical even in cases of phantom limb pain, or cases where there is no bodily disruption outside of the central nervous system, and moreover, painkillers might actually diminish this bodily badness, at least temporarily. If this is so, then we are not free to stipulate the normative details as we stipulated them two paragraphs above.

6 Strong Naïve Evaluativism: The Normative Force of Painkillers

Shouldn't philosophical reflection suffice to show that taking painkillers doesn't diminish whatever bodily badness is there? This is not a challenge to naïve evaluativism as such. The naïve evaluativist can allow that in general, taking painkillers (aside from anti-inflammatories) does not actually make anything less bad. But here I will suggest that the naïve evaluativist can go further: I will outline an argument that painkillers — even those that do nothing to lessen inflamation or otherwise heal damage — may in general diminish bodily badness, at least temporarily.

To frame the issue, I will follow Cutter and Tye (2011)'s suggestion that the kind of badness that pain experience represents is aptness to derail an organism's function. We can all agree that pain experience often has negative, function-

derailing consequences. One reason to take painkillers (as Cutter and Tye 2014 discuss) can be anticipation of these: you might take painkillers not because pain is unpleasant but because you want to be able to get to sleep, think clearly, exert willpower.

But we can equally think of these negative function-derailing consequences as consequences of the state of tissue damage itself, precisely because the tissue damage is the origin of the causal chain that leads to those consequences in normal cases — that is to say, cases in which it is experienced. In other words, the fact that the state of tissue damage tends to elicit these responses makes it even worse. But by taking painkillers one negates this further derailing tendency, thereby diminishing the badness to some degree.

This means the negative secondary consequences of pain have two normative roles to play: they directly give one reasons to take painkillers (as Cutter and Tye 2014 maintain), and they also play a constitutive role in augmenting the degree of bodily badness. In their first role, the negativity of the effects is reason-giving in its own right. In their second role, the fact that a bodily state leads to these effects helps to explain what makes that bodily state bad. Thus there is a feedback effect by means of which the cause of an experience of badness comes to be bad in virtue of causing an experience of badness.

It is easiest to see how this works in a case where a pain experience veridically reports tissue damage. For then the tissue damage is bad to some extent independently of this feedback effect, but by causing an experience of pain which has negative consequences, the tissue damage is worse than it otherwise would be.

Importantly, it depends on the specifics of the case whether the overall effects of a pain experience are more likely to be bad or good. This may hinge on the extent

to which the pain experience is, in the terminology of Martinez (2015), *spammy* — whether the message it sends is useful, or merely an unnecessary distraction. But plausibly taking painkillers is appropriate to the extent that the pain experience is spammy, so this is support for the thesis under consideration.

But the feedback effect also applies in cases where the tissue damage reported by the pain is misrepresented. For the claim under consideration here is that the bodily source of the causal chain that leads to the negative consequences is the locus of badness. In perfectly veridical cases this source is the tissue damage that your pain reports. In cases of referred pain (e.g., a case where you are having a heart attack and you feel a pain in your back and shoulders) this source is a different instance of tissue damage. In a case where your pain experience has no cause at all beyond your central nervous system, it may seem that there is nothing plausibly construed as bad.[26] But to the contrary, the relevant state of your central nervous system is bad, precisely because, and to the extent that, it is apt to lead to pain experience which is apt to lead to negative secondary consequences.

I stress that this is not a 'response-dependent' theory of the badness of pain. It is also not a theory according to which pain experience represents *its own* badness. It is a theory according to which causing (spammy) pain experiences makes a physical state worse than it otherwise would be: not because pain experience is intrinsically bad, but because (spammy) pain experience is apt to have further negative consequences.

I do not pretend that this theory fully vindicates the experience we have upon taking a very powerful painkiller in response to a serious injury. A very powerful

[26]Such cases may arise, potentially as a result of localized ischemic or hemorrhagic strokes in the thalamus. See for discussion Quiton et. al. (2010).

painkiller can perhaps make it seem as though there is no longer anything bad happening at all, which is to obliterate the non-spammy core of an experience of, say, a broken shin. But it is not obvious that we ought to be taking painkillers like that, just as it is not obvious that we ought to be taking hallucinogens or euphoria-inducing drugs.

I conclude that philosophical reflection does not automatically lead us to the conclusion that the experience of painkillers ameliorating bodily badness is non-veridical. Painkillers may well ameliorate bodily badness.[27]

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